

TRANSACTIONS
OF THE
CHICAGO SURGICAL SOCIETY.

Stated Meeting, February 6, 1905.

D. A. K. STEELE, M.D., in the Chair.

ANKYLOSIS OF THE JAW.

DR. EMIL RIES reported the case of a man, twenty-one years of age, who was sent to him from Indiana six months after he had acquired syphilis. The patient's syphilis was at first treated by some irregular practitioner in an unknown way, and grew worse rapidly. He soon began to have ulceration of the mouth, though he did not remember ever having been salivated, and it was not known that this practitioner gave him mercury. At any rate, ulceration of the mouth began, and when the young man consulted a regular practitioner he was in a very bad condition. His tongue was swollen enormously; he could not close his mouth; his mouth was full of ulcerations; he lost almost all of his teeth on the left side; large pieces of bone began to come out. One day a very severe haemorrhage from the mouth took place, which the doctor had difficulty in controlling. Then under antisyphilitic treatment this very bad condition became a little better, so that the tongue retired into the mouth and the patient could close the mouth. Very soon, however, he found that, whereas before he was unable to close his mouth, now he was unable to open it. The teeth of the left side having largely fallen out, he was able to feed himself on that side with a spoon, taking liquid food only. He noticed that part of the liquid food always escaped through the nose, so that feeding was rather difficult. At first his nutrition was very poor; he went down rapidly, but

gained in weight under antisyphilitic treatment and careful feeding, so that when he came to Chicago in November he was in fairly good general health. In October, when Dr. Ries first saw him, he still had syphilitic ulcerations in the mouth which did not heal quickly, and he gave directions for specific treatment. When he returned in November he could not move the lower jaw; half of the horizontal ramus of the jaw on the left side had disappeared, with the angle of the jaw. Between the condyloid process and the jaw there was only ligamentous union by cicatricial tissue. The median line of the lower jaw corresponded vertically with the left nasolabial fold, the jaw being pulled over to the left side. There was a perforation of the hard palate; there was a perforation of the septum. There were condylomata on the penis; the chancre was still hard; the glands were enlarged all over the body; but there were no mucous patches, no eruption on the skin. It seemed that the man was as much troubled by the bad mutilation of his face in consequence of the absence of the angle of the jaw as by his inability to open the mouth. He desired very much to have something done for the caving in of the left side of his face, and, in determining upon the method to be followed in the operation, the speaker took that into account, and instead of making an incision along the zygoma, as would ordinarily be practised, he decided to do an operation which would permit him to insert a sufficient artificial support for his face to make the left side correspond more to the other side. He intended to insert sufficient ivory pegs to give the appearance of a natural jaw. He therefore made an incision below the horizontal ramus, or where it ought to have been, and continued it up behind the ascending ramus; then dissected his way down to the bone and to the cicatricial tissue, and dissected out the facial nerve and its branches carefully so as to avoid wounding them. After they had been dissected out they could be seen beautifully; he raised these parts forward, and on the left side tried to remove the condyloid process, which was firmly adherent to the skull. The coronoid process was buried in scar tissue, with the scar tissue extending down into the mucous membrane of the mouth, so that he was in considerable danger of opening into the mouth, an occurrence which he was particularly anxious to avoid to guard against infection of the wound. He succeeded in avoiding opening into the mouth, and could resect with the chisel the condyloid process.

The coronoid process, which fastened the rest of the jaw to the scar tissue, he dissected out subperiosteally. Then he expected the jaw to be fairly movable. It was not. It was just as solid as it was before. Even after the condyloid process had been removed completely, there was no possibility of moving the jaw. He therefore decided that it would be necessary to operate on the other side also; and he sutured the pterygoid muscle out between the skull and the external soft parts so as to avoid new bony formation between the base of the skull and the jaw. He then proceeded in the same way on the right side, but it was sufficient to resect the condyloid process, as the coronoid process had not interfered sufficiently with the motion; and he again sutured the pterygoid muscle out between the skull and the rest of the descending ramus of the jaw. On the left side, after having finished the dissection, he drilled holes into the jaw and inserted ivory pegs. At first he had two pegs ready, but found that, if he drilled a sufficiently good hold for the second peg, he would run considerable risk of getting into the alveolar process and of opening into the mouth, and, of course, one could not expect pegs to hold for any length of time if they were in contact with the mouth cavity in any way. He therefore left one peg in place, which he could insert into the horizontal ramus, and which healed in beautifully. The wounds were closed completely by sutures, without drainage, and healed by primary union. At the end of the operation it was possible to open the mouth sufficiently to insert a good-sized piece of bread, or anything of that kind, so that the man would be able to eat solid food.

In the after-treatment he insisted on early and frequent passive motion; then he began to teach the man to speak again. His speech, when he came to him, was mumbling, very indistinct, in consequence of the formation of scar tissue in his mouth, and he actually had to relearn to speak. At the end of six weeks' treatment his mouth was clean and all right; the wounds were all healed; his mobility was very fair, and he proceeded to have a dentist insert a plate, first of all covering the opening into his nose, the perforation of the hard palate, and, secondly, to enable him to chew. He was then able to chew food, if it was not too hard, and when he left the hospital, about eight weeks after the operation, he was in good condition, and his face looked quite natural. There was still a little caving in on the left side, but the

ivory peg held up the skin so well that there was a marked apparent angle of the jaw, and the deep cavity which had existed at first on the left side had disappeared. Now, that the peg had healed in, he thought it would be an easy matter to build up with paraffin the side of the face, as there was something to build up on. The patient was going to return soon to have some more dental work done, and at that time the speaker expected to inject some paraffin.

EXTENSIVE RECTAL STRICTURES.

DR. RIES described a case which he had reported, first, seven years ago. At that time he operated upon a woman with syphilis of long-standing. She came to him with the complaint of constipation, vomiting, cachexia, suppuration from the rectum and vagina, and in whom he found on examination the following choice selection of conditions: Syphilis, with skin eruption; general enlargement of the glands; extreme cachexia, so that the woman, instead of weighing 160 pounds (her former weight), now weighed only eighty pounds; complete laceration of the perineum; rectovaginal fistula; stricture of the rectum, low down, and very tight, so that he could barely introduce a thin probe; laceration of the urethra; cystic tumors of both ovaries of moderate size, say about the size of a goose-egg. On vaginal examination the uterus was found atrophied and high up. Behind the uterus he found a hard mass, the nature of which he could not explain. He thought it was a case of mesosigmoiditis, which was associated frequently with ulcerative processes low down in the rectum or higher up in the sigmoid. He intended to resect the stricture of the rectum and bring down the sigmoid and attach it to the sphincter ani. He proceeded accordingly (June 19, 1897) through the vagina, and as he split the fistula he found it went through into the stricture. Above the stricture there was ulcerated rectal mucous membrane, and going higher up he came into the peritoneal cavity. In the peritoneal cavity he found a hard mass higher up, which was not simply a mesosigmoiditis, but a second stricture of the rectum, so that the following conditions confronted him. Diagram (Fig. 1) shows the symphysis, the bladder, with laceration of urethra; the vagina, with the uterus, the lacerated perineum, and fistula which led into the rectum.

Then the sacral bone, the upper stricture, the dilated, ulcerated portion of the rectum, with the lower stricture. After he had opened into the peritoneal cavity, it was clear that he could not have pulled down the bowel above the upper stricture from below without running serious risk. So he turned the patient round and did a laparotomy. The descending colon was loose to such an extent that there was a distinct mesentery, so that he cut

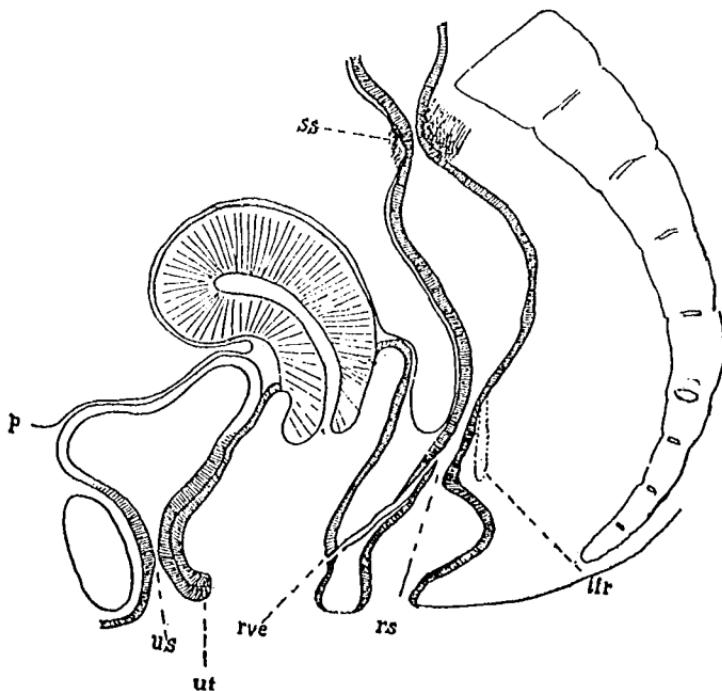


FIG. 1.—Condition before operation. *p*, Peritoneum. *ss*, Stricture of sigmoid. *rs*, Stricture of rectum. *ifr*, Internal fistula. *rve*, Rectovaginal fistula. *ut*, Urethral tear. *us*, Urethral stricture.

through above the upper stricture, and closed the lower part of the bowel completely. He took the descending colon, pulled it down through the opening in the cul-de-sac, and inserted it above the anus. There were therefore at the conclusion of the operation two rectums, a new one, which was made of the descending colon, and the old one, which contained two strictures, and an ulcerated area (Fig. 2). The anastomosis was made by sutures.

In other words, exclusion of the lower part of the bowel was performed. The woman made a smooth recovery, gained in flesh rapidly, and had no difficulty with her bowel movements after that for five years.

He reported this case to the Chicago Medical Society soon after it was operated upon. He also reported it to the Mississippi Valley Medical Association five years after the patient had been

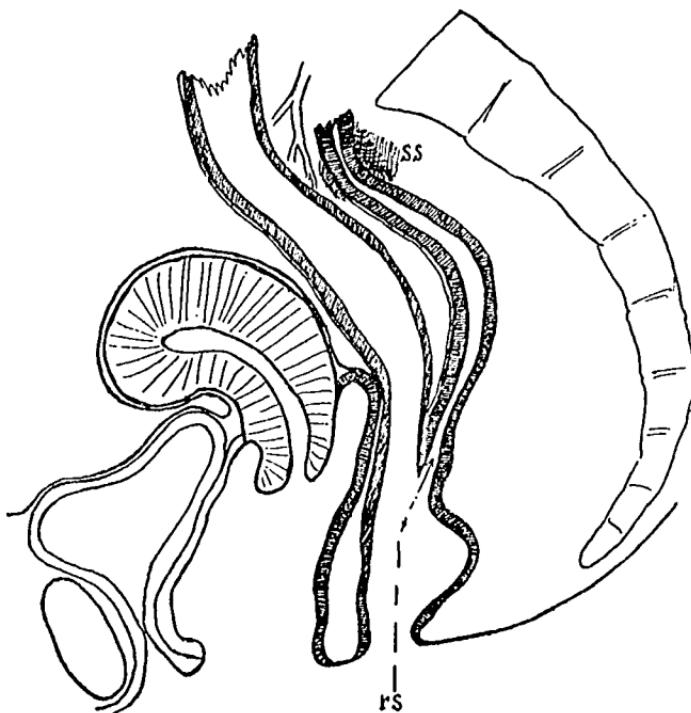


FIG. 2.—Operation completed. *rs*, Rectal stricture. *ss*, Stricture of sigmoid.

operated upon, when she weighed 160 pounds. At that time she was in perfect health. She complained of nothing, had done nothing for her syphilis, and could not be induced to take any kind of treatment. He saw the woman again two months ago, when her weight had been reduced to ninety-six pounds. She was cachetic, and the new rectum was as much strictured as the old one was before. The excluded bowel had shrivelled up com-

pletely, so that it was impossible to introduce a probe more than an inch. The rest was all closed up apparently by a cicatrical mass. The new artificial rectum had become strictured also, but the stricture was not so tight but what one could introduce a good-sized flexible bougie. The mass of cicatrical tissue around it was so extensive that there was little doubt in his mind but what the rectum would close completely. The body was covered with a specific eruption.

So far as he knew, this was the first case ever operated upon in this manner. The second case was operated upon by Rotter, of Berlin, about five weeks after Dr. Ries operated on his case; and that gentleman published a report of his case about ten months after he had operated, that is, over eleven months after Dr. Ries operated, he having the same idea in view. This gentleman had operated upon two additional cases since. One patient was dead, while the other two survived. Both had a recurrence, one two, and the other three, years after operation. Dr. Ries's case was the only one that had remained free from recurrence for over five years. He operated on her again last Saturday. It was interesting to go into the abdomen to see what the organs looked like at present. He expected, if he could get enough slack, enough movable colon descendens or transverse colon, to repeat the operation, and take the transverse colon and place it between the sacrum and vagina, and use it for a rectum. When he got in he found there was no slack. The descending colon, which was stretched at the time of the first operation, was smooth and laid almost immovably against the abdominal wall on the left side. There was no mesentery now on which to pull and drag in order to get the colon down to the sphincter ani. The transverse colon was not sufficiently movable to be cut in two and taken down into the pelvis. He therefore decided to do a colostomy, which he performed on Saturday. The woman was doing well so far.

DR. JACOB FRANK said that Dr. Beck had exhibited a case at a previous meeting of the Society in which he had excluded a portion of the bowel, and described a peculiar formation which took place in that excluded portion. He had had the same experience as Dr. Beck with regard to exclusion of the bowel, and also had demonstrated the same in experimental work on dogs. He did not know whether in Dr. Ries's case part of the bowel was completely excluded, or whether there was an opening at the

lower part, and he would like to have Dr. Ries speak of that in his closing remarks. He could not describe very well the particles of material that formed in the bowel, but so far as he could judge, they appeared to be of a cheesy nature, rolled up in little balls, and sometimes this material formed in such quantities that it gave patients excruciating pain. In one case, a woman, he had operated upon, the suffering was considerable, and he always thought when she came to him she complained simply of nothing. Why she complained, he did not know, because her bowels were moving; but the pain became so excruciating that he finally operated again, and found the condition he had mentioned. He would like to know whether Dr. Ries found anything of this kind in his case, or whether there was an opening through which the material could escape. This was the first case he knew of where the bowel became completely contracted to a small tube if both ends of the bowel were completely closed.

DR. RIES said, in reply to Dr. Frank, that the descending colon, which was pulled down, was inserted into the rectum just above the anus, and was not excluded at both ends, but only at one end. The excluded bowel was in an ulcerated and syphilitic condition, so that there was very little epithelium left. His patient was not bothered by the sebaceous or cheesy masses referred to by Dr. Frank. At first, there was a sort of mucous discharge from the rectum, but this soon stopped, and now one could not introduce a sound very far.

STRICTURE OF THE CESOPHAGUS FOLLOWING TYPHOID FEVER.

DR. S. C. PLUMMER presented a case of a young man, seventeen years of age, who, on September 21, 1903, took to his bed with typhoid fever. On October 15, while apparently convalescent, he suffered a relapse, and was severely ill for more than three weeks longer. Liquid diet was continued until about November 12. On this date he partook of semisolid diet for the first time, and noticed difficulty in swallowing, with frequent choking. This condition gradually grew worse, and about December 10 the attending physician began passing cesophageal sounds each day, until December 19, when patient was removed to another hospital. From December 19, 1903, to February 25,

1904, he received no treatment for the stricture, but from that date on a whalebone sound, with steel olive tips, was used.

On April 12 he became unable to swallow anything, even liquids, and was nourished by rectal alimentation. On April 18 he entered Wesley Hospital, Chicago, and on April 21 was anaesthetized with ether. An unsuccessful attempt was made to pass bougies of various sizes, and Dr. Plummer then proceeded to do a gastrostomy, using a vertical incision, with separation of the fibres of the rectus muscle, as advised by von Hacker. As it was impossible to enter the oesophagus through the cardiac orifice of the stomach, the stomach wall was stitched to the edges of the parietal peritoneum, and then opened. The edges of the stomach wound were not stitched to the skin, but brought up only slightly into the wound, and a drainage-tube inserted. It was not the aim to make a permanent fistula lined with mucous membrane, but it was hoped that the stricture of the oesophagus would relax, and the gastric fistula, after serving as a temporary route for nourishing the patient, might be allowed to close.

On April 27, six days after the operation, the patient could again swallow liquids. On the following day an attempt was made to pass a small bougie, but unsuccessfully. Several similarly unsuccessful attempts were made during the next few days. On May 4 the stricture again closed, so that liquids could not be swallowed, and on July 21 he gave up all hope of ever dilating the stricture, and the patient left the hospital. At this time he was strong and well nourished.

On August 26 he could again swallow liquids, and he returned to the hospital September 4. Attempts to pass bougies were unsuccessful, as before, so efforts were directed to getting something through the stricture by swallowing. Repeated efforts on the part of the patient failed, but on September 29 he informed Dr. Plummer that he thought a very fine silk thread had passed through. His stomach was quite full at the time, and upon removal of the tube, which was kept clamped with an artery forceps, there was a free escape of stomach contents, and the end of the thread floated out through the fistula. A heavier thread was at once attached to the mouth end of this one and drawn through the stricture, and to this a still larger thread attached and drawn through. The two ends of the latter were then tied together, first passing the stomach end through the drainage-tube. Each day

a larger thread was drawn through, and finally three of the largest were in place at one time. On October 18 a small drainage-tube was drawn through the stricture and allowed to remain two hours, then withdrawn, to be again drawn into place the next day. Every few days the size of the tube was increased, until early in January, 1905, a No. 14 catheter was used.

On January 11 the string was removed and the drainage-tube taken out of the fistula. A bougie was then passed through the stricture per mouth, and this had been continued every day or two up to the present time, when a No. 23 cesophageal bougie could be passed with ease.

On January 5, 1905, he began giving the patient thiosinamin, three grains, once a day. On January 12 this was increased to three grains twice a day, and on January 27 to three grains three times a day. On February 3 this was stopped, as patient complained of a feeling of weakness, which might, however, have resulted from his eating but a small amount of food, owing to the fact that his abdomen was strapped rather tightly with adhesive strips in the effort to close the fistula, and food when taken, except in moderate quantities, distressed him. The administration of the thiosinamin made it possible to increase the caliber of the bougies, and more rapidly than ever.

The fistula at this time (February 6) was about the diameter of a lead-pencil.

COLLOID CARCINOMA OF THE CÆCUM.

DR. PLUMMER reported the case of a female, aged twenty-five years, who in the summer of 1901 was seized with pain in the right iliac region. The onset was gradual, and followed in about forty-eight hours by vomiting and high fever. She remained in poor health for six weeks, when a diagnosis of appendicitis was made, and appendix removed. She recovered slowly after operation, but complained chiefly of weakness.

In August, 1903, patient began to have attacks of pain, vomiting, and fever, lasting ten to fourteen days at a time, with intervals of several weeks. Pain was cramping in character, and more generally distributed than before. The latter part of July, 1904, she noticed a slight swelling in the right iliac region. She had pain in the right iliac region, which radiated at times into

SARCOMATOUS DEGENERATION OF UTERINE MYOMA. 147

the right lower and upper extremities. She experienced some difficulty in walking. There was much distention of the bowels by gas, with constipation.

Examination revealed a firm mass, not adherent to the abdominal wall, with limited mobility.

Operation, September 22, 1904. A small incision was made over the tumor, and when the nature of the tumor mass was recognized, by examination through this opening, a long median incision was made. The ileum was divided near its lower end. Since it was found that the ascending mesocolon contained enlarged lymphatic glands, almost the entire ascending colon and its mesocolon were removed along with the cæcum, the colon being cut across near the hepatic flexure. The ends of the divided bowel were closed by two rows of sutures, and a lateral anastomosis was made by a Murphy button between the ileum and the transverse colon. The ileum was dilated and its walls much thickened. The abdomen was closed without drainage.

The patient had a tedious convalescence. For many days she suffered from great abdominal pain, with occasional emesis, and got very little sleep. Gradually, however, she improved, and on October 25 sat up in bed. The button did not pass until October 23, thirty-one days after the operation. On October 27 she was up in a wheel-chair, and on November 3 walked. When she left the hospital, November 24, 1904, she was in a fair condition, and when seen last, about January 1, 1905, was in vigorous health.

The fresh specimen showed the walls of the cæcum much thickened and indurated, with the lumen so reduced in size that the little finger could not be passed through it. Adherent to the cæcum was a colloid mass, almost the size and shape of a hen's egg; and there were several similar masses of smaller size in the immediate vicinity.

SARCOMATOUS DEGENERATION OF UTERINE MYOMA.

DR. E. C. DUDLEY exhibited a gross specimen and some slides of this case, and said that it was generally understood that sarcoma might develop from any of the following structures:

1. The interglandular connective tissue of the endometrium.
2. The intermuscular connective tissue of the myometrium.
3. The walls of the blood-vessels.
4. Perivascular connective tissue.
5. The muscle cells.
6. Any of the structures of a uterine myoma.

In the interesting specimen under consideration, it was evident from gross appearances that the sarcoma had developed from a uterine myoma. Before operation, the sarcomatous structure filled the uterine cavity, and felt on intra-uterine palpation like a retained placenta; in fact, was so pronounced by two excellent diagnosticians. Microscopic sections taken from various parts of the growth showed it to be a small, round, and spindle-celled sarcoma, the sarcomatous cells being substantially of the same size as the red corpuscles. The interesting features of this specimen were: (1) A rather sharp demarcation between the sarcomatous cells and the myomatous cells. (2) Presence in many parts of the sarcoma of clearly defined blood-vessel walls. (3) The transition in the character of the blood-vessels from those which have walls to those which are mere blood-spaces.

In this case complete abdominal hysterectomy was performed on the 17th of November, 1904. There was nothing unusual in the operation or in the subsequent recovery of the patient.